	3400 ST	DDRESS, CITY, STATE, ZIP CODE  OCKER DR  //LLE, IN47720  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE	COMPL 04/14/20	
B. W. FION CENTER EFICIENCIES CEDED BY FULL	STREET AI 3400 ST EVANSV  ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	04/14/20	011
ION CENTER EFICIENCIES CEDED BY FULL	STREET AI 3400 ST EVANSV ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
EFICIENCIES CEDED BY FULL	3400 ST EVANSV ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
EFICIENCIES CEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1	
CEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		
	1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5)
G INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
		DEFICIENCY)		DATE
estigation 4.  tate 272, 514. e cited	F0000	Pine Haven POC By submitti the enclosed material we are admitting the truth or accurace any specific findings or allegations. We reserve the responses to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The frequests that the plan of correction be considered our allegation of compliance effe May 14, 2011 to the complain survey conducted on April 14 2011.	ing e not cy of right se facility ective nt	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K11

Facility ID:

000442

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET . 3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	findings cited 42 CFR Part 4 IAC 16.2. Quality review	type:  acies also reflect state in accordance with 83 Subpart B and 410  completed on April ev Faulkner, RN			

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	` ′	e survey pleted /2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP TOCKER DR SVILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F0225 SS=A	have been found or mistreating resistance had a finding nurse aide registry mistreatment of resistance of their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities.  The facility must eviolations involving abuse, including ir and misappropriate reported immediate the facility and to with State law through (including to the Sagency).  The facility must halleged violations and must prevent the investigation is the reported to the addrepresentative and accordance with State survey and oworking days of the	nvestigations must be ministrator or his designated to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective				

Facility ID:

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		155621	A. BUI B. WIN	LDING G		04/14/2	011
NAME OF F	PROVIDER OR SUPPLIER			_	ADDRESS, CITY, STATE, ZIP CODE		
				1	TOCKER DR		
		REHABILITATION CENTER		<u> </u>	VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
			FO	)225	F225		05/14/2011
	review, the fact an allegation of property to the Department of within the requirement of the property of the	Health [ISDH] uired time frame, for s reviewed for abuse, 6. Resident D  de:  9:00 A.M., the provided a Report," sent to the		0225	It is the practice of this facility assure that the misappropriate of resident funds is reported appropriate agencies on a tin basis as required by regulation.  The correction action taken for those residents found to be affected by the deficient practice inclused.  The misappropriation of Resident Practice inclused in the misappropriation of Resident Practice inclused.  The misappropriation of Resident Practice inclused in the sequence of the practice inclused in the sequence of the practice in the properties of the practice in the properties of the practice of the p	tion to the nely on.  or fected de: dent n ly. ues ng been be ce. been dicy to ng of ator ence nt is no fected to unges to	05/14/2011
	she indicated s immediately re	she did not eport the resident's			The policy related to reporting abuse or misappropriation of r funds has been re-inserviced to	esident	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) N	AULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RII	ILDING	00	COMP	LETED
		155621	B. WI			04/14/2	2011
			F. ''11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	TOCKER DR		
	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	•	nissing money to the			assure a thorough understand the regulation including the r	-	
	ISDH. The Ad	ministrator indicated			of unusual occurrences in a ti		
	she waited unt	il the investigation			manner. All staff having a ro		
	was completed	l before she reported			implementation of this policy	have	
	the incident.	1			been in-serviced.		
	ino moraciit.				The corrective action taken t	0	
	2.1.20()				monitor performance to assu		
	3.1-28(c)				compliance through quality		
					assurance is:		
					A Performance Improvement	Tool	
					has been initiated that will be		
					to review prompt adherence t		
					abuse policy, including notifi		
					of the appropriate state agence		
					the Administrator's responsib assure that the appropriate ag	-	
					are notified of any allegations		
					timely manner. The Administ		
					designee, will complete this a	ıudit	
					monthly x3, then quarterly x3		
					Quality Assurance Committe		
					review the results of the audi		
					scheduled meeting following completion of the audit with	the	
					recommendations as needed.		
					2500mmendations as needed.		
					The date the systemic change	es will	
					be completed:	<b>17888</b>	
					May 14, 2011		
F0226		evelop and implement					
SS=A		d procedures that prohibit					
		lect, and abuse of residents ion of resident property.					
		view and record	F	0226	It is the practice of this facil	ity to	05/14/2011
					-		ļ
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	144K11	Facility 1	ID: 000442 If continuation	n sheet Pa	ige 5 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621		(X2) MI A. BUII B. WIN		NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011	Ĭ.	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) PLETION ATE
	review, the fact implement the an allegation of property to the Department of within the des for 1 of 6 residuabuse, in a same Findings included:  1. On 4/13/11 Administrator facility policy Prohibition," of included:  "Allegations/s abuse will be immediately to and well being 'Abuse' means of injury, unreconfinement of goods or senecessary to mediatelyFinance	cility failed to cir policy of reporting of misappropriation of e Indiana State f Health [ISDH] ignated time frames, dents reviewed for mple of 6. Resident D  ide: at 10:00 A.M., the provided the current on "Abuse dated 2/11. The policy uspicions/reports of investigated o ensure the safety g of the resident. I the willful infliction casonable includes deprivation			assure that the Administrator notified immediately related to allegation of abuse, neglect, or misappropriation of property. Administrator is then responsi for notifying the appropriate agencies as required in a timel manner, per the facility policy the regulation.  The correction action taken for those residents found to be affee by the deficient practice include.  Resident #D has had no further issues related to misappropriation funds. Please refer to systemic changes related to policy and reporting mechanisms to the appropriate state agencies.  Other residents that have the potential to be affected have be identified by:  Potentially, all residents could be affected, and therefore the curre policy has been re-inserviced to assure a thorough understanding the regulation.  The measures or systemic chant that have been put into place to ensure that the deficient practice does not recur include:  The policy related to reporting of	The ble y and cted e: on of ent g of ges	
	conduct with o	or without informed older adult that			abuse or misappropriation of res funds has been re-inserviced to assure a thorough understanding the regulation, including the		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	ETED
NAME OF I	PROVIDER OR SUPPLIE	{	•	1	ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
	results in monother benefit, proprietor or results in situations will immediately a appropriate au agencies"  2. On 4/14/11 Administrator "Fax/Incident sent to the ISI included, "In 1/23/11It was 1/15/11 that a name] reporte were missing stated that it we \$40.00 worth	REHABILITATION CENTER  STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LESC IDENTIFYING INFORMATION)  Retary, personal or gain or profit for the monetary or personal der adultReported my of the above be investigated and reported to the atthorities and  at 9:00 A.M., the provided a Report," which was OH. The report incident Date as reported to me on resident on [unit d that her quarters from her room. She was [approximately] of quarters"		3400 ST	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  reporting of unusual occurrence timely manner. All staff having role in the implementation of the policy have been in-serviced.  The corrective action taken to monitor performance to assurance is:  A Performance Improvement Thas been initiated that will be used to review reportable events to a that they are reported timely in accordance with the facility power and the regulation. It is the Administrator's responsibility assure that the appropriate agent are notified of any allegations in timely manner. The Administrates designee, will complete this aumonthly x3, then quarterly x3. Quality Assurance Committee review the results of the audit as scheduled meeting following the completion of the audit with recommendations as needed.  The date the systemic changes	es in a g a his  fool attilized assure licy to ncies in a ator, or dit The will at the	(X5) COMPLETION DATE
	interview with she indicated immediately r complaint of r	11:50 A.M., during the Administrator, she did not eport the resident's missing money to the dministrator indicated			be completed:  May 14, 2011		
	she waited un	til the investigation					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMP 04/14/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIP CO TOCKER DR WILLE, IN47720	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	was completed the incident.	l before she reported				
	3.1-28(a)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621			(X2) MULTIPLE  A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155621	B. WING		04/14/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	3400	ET ADDRESS, CITY, STATE, ZIP CODE STOCKER DR NSVILLE, IN47720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  The facility must conduct initially and		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	periodically a compstandardized repro- each resident's fur  A facility must make assessment of a residentification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well-Physical functioning Continence; Disease diagnosist Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentiar Documentation of regarding the additional performed through protocols; and Documentation of Based on observe items, and interest failed to ensure comprehensive completed in residential control of the state of the	prehensive, accurate, oducible assessment of actional capacity.  The accomprehensive desident's needs, using the acceptance of the State. The assessment ast the following: demographic information; it is particularly and structural problems; and health conditions; and status;  The accuracy of the acceptance of the second of	F0272	Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Centi assure tihati residentis are assess properly relatied tio fiall risk and an investigation is implementied relatied tio tihe fiall as tio tihe pocause so tihati appropriatie intierventions can be implement tio assisti witih tihe prevention or reoccurrence.  The correcton acton taken fior	sed tihati ossible ied
	completed, for	3 of 3 residents		The correcton acton taken fior	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K11

Facility ID:

000442

If continuation sheet

Page 9 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155621		LDING	00	04/14/2011
		133021	B. WIN		Paraga gray galang gray gara	04/14/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
DINE HA	VEN HEALTH AND	REHABILITATION CENTER			TOCKER DR VILLE, IN47720	
				L	VILLE, IIV-1120	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
		alls, in a sample of 6.			those residents fiound to be afie	cted
		•			by the deficient practce include :	
	Residents A, E	o, and C			Residentts#A and #C have been	
					reassessed relatted tto flall risk ar	
	Findings include:				have been reviewed by tthe IDT to	to
					assure tthatt appropriatte intterventtons are in place tto ass	ictt
	1. On 4/14/11	at 9:30 A.M., the			witth tthe preventton of flalls	
		ance nurse provided			Residentt#B, as identtfled in tthe	
		-			2567, no longer resides att tthe	
	the current facility policy on "Falls				flacilitty	
Prevention," dated 9/08. The policy included: "To ensure that					Other residents that have the	
					potental to be afiected have bee identfied by :	n
	residents are safe and that				All residentts have been assessed	
	appropriate pro	eventive measures are			relatted tto flall riskBased on tthe	
		nimize injuries			assessmentt intterventtons have l	been
					implementted tto assistt witth tth	e
		. Procedure, If a fall			preventton of ffalls	
	ĺ	lls Checklist will be			The measures or systematc changes that have been put into	
	initiated with a	all areas completed			place to ensure that the deficient	
	before the end	of the shift the			practce does not recur include :	
	incident occur	redNursing staff			The IDT Committee will begin	
		on the resident chart			reviewing any residentt who has	
	a thorough acc				experienced a flall tto assure ttha	
	l	•			based on tthe assessmentt of tth possible cause of tthe flall appro	
		lined in the Falls			intterventtons are implementted	
	Checklist. Fall				assistt witth tthe preventton of	
	MeasuresMo	otion Alarms			reoccurrence of flalls The nursing	g
	(Bed/Chair)l	Motion Sensors,			sttafl has been inserviced relatted	
	Smart Floor M	· · · · · · · · · · · · · · · · · · ·			flall preventton and tthe inittattor	
		Releasing Alarm Belts,			tthe investtgatton flor immediatte intterventton	;
		~			The correctve acton taken to	
		l preventive measures			monitor perfiormance to assure	
		with the resident's			compliance through quality	
	cognition level	1."			assurance is:	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155621	A. BUI	LDING	00	COMPLETED 04/14/2011
		100021	B. WIN			04/14/2011
NAME OF F	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720	
		TATEMENT OF DEFICIENCIES			VILLE, IIVI7720	(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
					A Perflormance Improvementt Too	ıl
	2 On 4/13/11	at 2:00 P.M., Unit			has been inittatted tthatt will be	
		rovided C.N.A.			uttlized tto review residentts tthat	
					considered "att risk flor flalls" or ha had an acttual flall tto assure tthat	
	_	eets for her unit. The			intterventtons are in place tto prev	
		eets indicated that 23			flalls and tthatt ifl a flall occurred t	thatt
		ed on that unit.			an investtgatton in inittatted tto as	
	Seventeen (17)	of those 23			tthatt appropriatte intterventtons	
	residents had s	ome type of fall			implementted tto assistt witth tthe preventton ofl flutture flalls his tto	
	prevention alarm to alert staff of				will randomly review 5 residentts	
	unassisted rising.				The Directtor ofl Nursingor designe	ee,
					will complette tthis ttool weekly3x	
	On 4/14/11 at	10:00 A.M., during			montthly 3, tthen quartterly 3. Any areas identtfled via tthe auditt will	
		,			immediattely correctted The Qualit	
		the compliance			Assurance Committee will review t	the
	nurse, she indi				ttool att tthe scheduled meettng	
	1	was to validate that			flollowing tthe completton of tthe witth recommendations as needed	
	"everything re	garding a fall was			The date the systemic changes wi	
	documented pr	coperly, including			be completed:	
	updating the ca	are plan." The			5-14-11	
	compliance nu	rse indicated there				
	•	an investigation on				
	_	urs," and that the				
	_	*				
		tion following a fall				
	would be to ad	ia an aiarm.				
	3. On 4/13/11	at 9:10 A.M., during				
	the initial tour,	, Unit Manager # 1				
	indicated Resi	dent A had fallen the				
	previous night	, and was not				
	•	Unit Manager # 1				

000442

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155621			LDING	NSTRUCTION  00	(X3) DATE : COMPL <b>04/14/2</b>	ETED
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1710		dent A required a		1710	·		DALL
	sensor pad alarm to her wheelchair						
	and bed. Unit						
		os alarm was added to					
		following the fall					
	the previous night.						
	1						
	The clinical record of Resident A						
	was reviewed on 4/13/11 at 10:40						
	A.M. Diagnoses included, but were						
	not limited to, Dementia.						
	A Minimum D	Oata Set [MDS]					
	assessment, da	ated 1/17/11,					
	indicated the r	resident scored a 9 out					
	_	nitive assessment,					
	-	ed assistance of 1					
		er and ambulation,					
	and had not fa						
	•	sment. A test for					
		ng transitions and					
	_	cated "Not steady,					
	-	abilize with human					
		nile moving from					
	seated to stand						
		surface-to-surface					
	transfer.						
	A "Fall Risk"	assessment, dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  00		(X3) DATE SURVE COMPLETED <b>04/14/2011</b>		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STRE 3400	ET ADDRESS, CITY O STOCKER DR NSVILLE, IN47	2		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	DER'S PLAN OF CORRECTION LECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA' DEFICIENCY)	E	(X5) MPLETION DATE
TAG	1/19/11, indicatintermittent con in the previous balance probles required the use device, and hat The assessment score of 10 or HIGH RISK."  Nurse's Notes following notated to the second of 10 or HIGH RISK."  Nurse's Notes following notated to the second of the second	ated Resident A had onfusion, had 1-2 falls as 3 months, had a sem while standing, see of an assistive d a total score of 12. In tindicated, "Total above represents for falls.  O P.M.: "Staff sident] yelling out entering res bathroom sitting on bottom of eaks [sic] locked. Resigury, none assisted off floor we assist x [two] staffRes. placed to bed, and] functioning, call ach. TABS alarm w/c for preventative re related to ty awareness."	TAG		DEFICIENCY)		DATE
	4/13/11 at 1:00	A.M.: "Resident					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/14/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	off bed alarm bed. Instructed alarms alone of getting up."	chair. Resident shut [before] getting out of d resident to leave et call for help before  9:00 A.M., the					
	"Incident/Acc 4/12/11. The i "Noted res of apparent injur noteAdditionsteps to prever alarm to w/c."	ident Report," dated report included, on floor[no]  y, refer to nurses nal comments and/or nt recurrence: tabs  The compliance d at that time that she of the reason the					
	the initial tour nurse indicate diagnosis of A	at 9:10 A.M., during r, the compliance d Resident C had a Alzheimer's Disease, of several falls, and s.					
	C was observe	11:30 A.M., Resident ed sitting in a a lounge, asleep. A					

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MI A. BUII		NSTRUCTION 00	COMPL	ETED	
		155621	B. WIN			04/14/2	J11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	self release sea	atbelt alarm was					
	observed on th	e resident. No staff					
	were observed	interacting with the					
	resident.						
		cord of Resident C					
		on 4/13/11 at 11:45					
		es included, but were					
	· ·	Alzheimer's Disease					
	and Parkinson	's Disease.					
	A Minimum D	ata Set [MDS]					
		ated 2/8/11, indicated					
	ŕ	d a short-term and					
		nory problem, was					
	_	paired in cognitive					
	_	decision-making,					
	required exten	sive assistance of					
	two+ staff for	transfer and bed					
	mobility, and o	did not ambulate. A					
	test for "Balan	ce during transitions					
	and walking" i	ndicated "Not steady,					
	only able to sta	abilize with human					
		ile moving from					
		ling position, moving					
	on and off toil						
		face transfer. The					
		ent indicated the					
	resident had no	ot fallen since the					

		i '		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BI	UILDING	00		COMPI		
		155621	B. W	ING			04/14/2	U11	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STA	ATE, ZIP CODE			
					OCKER DR				
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS	VILLE, IN47720				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEF	TICIENCY)		DATE	
	previous assessment.								
	Nurses Notes i	included the							
	following nota								
	10110willig 110ta	mons.							
	2/15/11 at 5:30	) P.M.: "CNA							
	approached Re	esident room et heard							
	alarm sounding	g. Resident found in							
	bathroom floor	-							
		sident asked what							
	* *	stated 'was going to							
	bathroom.' Res	sident toileted after							
	writer evaluate	ed."							
	   2/15/11 at 5:45	5 P.M.: "[Physician]							
		- · ·							
	•	dent. Received new							
	· ·	, C/S [urinalysis,							
	culture and ser	nsitivity]. Also							
	received order	s for self releasing							
	seat belt"	-							
	A UEalla Casa	Dlan II initialla data 1							
		Plan," initially dated							
	6/10, indicated	•							
	"History of fal	lsContributing							
	factors, Alzhei	imer's Diagnosis,							
	Forgets to ask	•							
	assistanceGe								
	weakness" T								
	indicated, "E	Encourage to stay							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	I I44K11	Facility I	D: 000442	If continuation sh	neet Pa	ge 16 of 55	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		ľ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SU COMPLET 04/14/20	ГED	
		155621	B. WIN			04/14/20	11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
		REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1.	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	seated or wait	for assistance before					
	transferring after mealsIs at risk						
	for falls; will u	ise the following					
	preventive me	asure: Sensor pad to					
	bed/recliner1	12/7/10 tabs alarm to					
	w/c, 2/15/11 S	elf releasing seat belt					
	while in w/c."						
	0 4/14/11	10.00 + 16.1					
		10:00 A.M., during					
		the compliance					
		cated there was not a					
	1 *	ch the cause of the					
	fall was assess	ed.					
	5. The closed	clinical record of					
	Resident B wa	s reviewed on					
	4/13/11 at 1:20	P.M. Resident B					
	was admitted t	to the facility on					
		iagnoses including,					
	but not limited	-					
		gery/digestive system.					
		care plan, undated,					
	indicated: "Fal	•					
	Risk/Elopemen						
		remain free of injuries					
	and falls. Keep	call bell in reach.					
	Enc. use of call light. Instruct						
	resident on saf	Pety					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155621	B. WIN			04/14/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	measuresMobility alarm SPA						
	[sensor pad ala	arm] bed [and]					
	chair"						
	Nurses Notes i						
	following nota	uons:					
	   3/25/11 at 3·00	A.M.: "Res remains					
		this time D/T [due to]					
	0	family is here et this					
	us a hotelthi	nks that nephew was					
	in the bed next	t to her"					
	0/05/11 11 /						
		00 A.M.: "Alert					
		onfusionneeds					
		st [with] ADL's aily living]"					
ı	[activities of a	any nymgj					
	3/25/11 at 3:30	P.M.: "Res spa					
		arm] heard sounding,					
	CNA went to r	resident's room,					
	resident found	lying on back on					
		of closet. Denies pain,					
	bruise noted to						
		sted to w/c [with]					
	assist x 3"						
	   3/25/11 at 3·4 <sup>4</sup>	5 P.M.: "Prevantive					
		t recurrent fall -					

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	LETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	•	3400 S1	DDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	self-release season on 4/13/11 at interview with nurse, she indicated and 3/25/11, "prob P.M.," and a seplaced on the rewiselection wheelchair. The indicated she of documentation attempt at unawas not in the did not know wattempted unattempted unattempted unattempted unattempted to see determine why attempted to see a self-release see	at belt"  2:15 P.M., during the compliance cated she would not ed Resident B She indicated dattempted oulation earlier on ably around 2:00 ensor alarm was resident's bed and ne compliance nurse did not know why a regarding the ssisted ambulation clinical record, and why the resident ssisted ambulation. The contraction is a process to the resident had elf-ambulate, and			CROSS-REFERENCED TO THE APPROPE		
	This federal ta Complaint INO 3.1-31(a)	g relates to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/14/2011	
	PROVIDER OR SUPPLIER		3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	A facility must use assessment to deveresident's compressorable object a resident's medic psychosocial need comprehensive as  The care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as the care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as the care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as the care plan must are to be furnished resident's highest mental, and psychosocial need comprehensive as the care plan must are to be furnished exercise of rights or required under \$40 to require and psychosocial need comprehensive as the care plan must be as a second or review, and in failed to developlans to ensure	the results of the velop, review and revise the nensive plan of care.  evelop a comprehensive resident that includes lives and timetables to meet al, nursing, and mental and list that are identified in the sessment.  It describe the services that it to attain or maintain the practicable physical, osocial well-being as 33.25; and any services that it required under §483.25 and due to the resident's under §483.10, including the timent under §483.10(b)(4).  Trivation, record terview, the facility op and revise care individualized	F0279	Iti is tihe practice ofi tihis fiaciliti assure tihati tihe residentis' care plans are developed and address tihe needs identified by tihe comprehensive assessmenti The correcton acton taken fior	y tio 05/14/2011
	fall prevention	vere implemented for , for 3 of 3 residents alls, in a sample of 6.		those residents fiound to be afiected by the deficient practce include : Residentts#A and #C have had care	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K11

Facility ID:

000442

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CON		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155621	B. WIN	G		04/14/2011
NAME OF E	PROVIDER OR SUPPLIER	1		STREET AI	DDRESS, CITY, STATE, ZIP CODE	•
					OCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANSV	/ILLE, IN47720	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Residents A, B, and C				plan reviewed tto assure tthatt tth	
					plan of care accurattely reflectts appropriatte interventions being	
	Findings include:				uttlized relatted tto tthe preventto	
					flalls Residentt B no longer reside	l l
	1 On 4/14/11	at 0.20 A M tha			tthe flacilitty	
		at 9:30 A.M., the			Other residents that have the	
		ance nurse provided			potental to be afiected have been	1
	the current fac	ility policy on "Falls			identfied by :	
	Prevention," da	ated 9/08. The policy			All residentts have been reviewed assure tthatt tthe plan ofl care	πο
	included: "To				addresses perttnentt inflormattor	,
	residents are sa				relatted tto flall preventton based	
					tthe assessmentt	
		eventive measures are			The measures or systematc	
	initiated to min	nimize injuries			changes that have been put into	
	related to falls.	Fall Preventive			place to ensure that the deficient	
	MeasuresMo	otion Alarms			practce does not recur include :	
		Motion Sensors,			The intterdisciplinary tteam is reviewing all flall risk assessment	s tto
	` /	· ·			assure tthatt perttnentt areas on	
	Smart Floor M				comprehensive assessmentt are	
	AlarmSelf-R	eleasing Alarm Belts,			identtfled as partt ofl tthe plan of	care
	RestraintsAl	l preventive measures			An in-service has been conductted	d flor
	must be added	to the Falls Care			tthe nurses tto assure tthatt tther	1
		All preventive			tthorough understtanding relatted	i tto
		•			tthe issues identtfled on tthe assessmentt being addressed on t	the
		correlate with the			plan of care flor the residentAs p	
	resident's cogn	ition level."			ofl tthe systtem changethe	
					Intterdisciplinary tteam will review	v all
	2. On 4/13/11	at 2:00 P.M., Unit			flalls assure tthatt an investigation	
		rovided C.N.A.			completted and assure thatt the	1
					plan has been updatted tto reflect	l l
	_	eets for her unit. The			appropriatte intterventtons based the possible cause of tthe flall	1011
	_	eets indicated that 23			The correctve acton taken to	
	residents residents	ed on that unit. 17 of			monitor perfiormance to assure	
	those 23 reside	ents had some type of			compliance through quality	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	144K11	Facility II	D: 000442 If continuation s	theet Page 21 of 55

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155621	B. WIN			04/14/2011
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		3400 ST	DDRESS, CITY, STATE, ZIP CODE  OCKER DR  VILLE, IN47720	
	SUMMARY S (EACH DEFICIENT REGULATORY OR Fall prevention of unassisted in the compliance of unassisted preventing reduction of unassisted in the compliance of	REHABILITATION CENTER  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  a alarm, to alert staff rising.  10:00 A.M., during the compliance leated that her was to validate that garding a fall was roperly, including are plan." The arse indicated there y an investigation on ars," and that the tion following a fall dd an alarm.  at 9:10 A.M., during , Unit Manager # 1 dent A had fallen the to, and was not Unit Manager # 1 dent A required a rm to her wheelchair Manager # 1		STREET A		e tto on is sed ofl te hen via
		os alarm was added to r following the fall ight.				
	The clinical re	ecord of Resident A				

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMP	SURVEY LETED
		155621	A. BUI B. WIN	LDING		04/14/2	
NAME OF F	DROVIDED OF CURRING		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	was reviewed	on 4/13/11 at 10:40					
	A.M. Diagnos	ses included, but were					
	not limited to,	Dementia.					
	A Minimum D	Oata Set [MDS]					
	assessment, da	= = = = = = = = = = = = = = = = = = =					
	indicated the r	resident scored a 9 out					
	of 15 on a cog	nitive assessment,					
	required limite	ed assistance of 1					
	_	er and ambulation,					
	and had not fa	llen since the					
	previous asses	sment. A test for					
	"Balance durii	ng transitions and					
	walking" indic	cated "Not steady,					
	only able to st	abilize with human					
	assistance" wh	nile moving from					
	seated to stand	ling position,					
	walking, and s	surface-to-surface					
	transfer.						
	A "Fall Risk"	assessment, dated					
	1/19/11, indica	ated Resident A had					
	intermittent co	onfusion, had 1-2 falls					
	in the previous	s 3 months, had a					
	balance proble	em while standing,					
	required the us	se of an assistive					
	device, and ha	d a total score of 12.					
	The assessmen	nt indicated, "Total					
	score of 10 or	above represents					
							1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
THIS TETAL	or connection	155621	A. BUII			04/14/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3400 S	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		EVANS'	VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	HIGH RISK"						5.112
		ioi iulio.					
	Nurse's Notes	included the					
	following nota						
	10110 Willig Hota	tions.					
	4/12/11 at 10:0	00 P.M.: "Staff					
		sident] yelling out					
		entering res bathroom					
	•	sitting on bottom of					
		eaks [sic] locked. Res					
	assessed for in	= = =					
		assisted off floor					
		ve assist x [two] staff					
		Res. placed to bed,					
		and] functioning, call					
		ach. TABS alarm					
	_	v/c for preventative					
	nursing measu	-					
	decreased safe						
		•					
	4/13/11 at 1:00	A.M.: "Resident					
	[up] getting in	chair. Resident shut					
		[before] getting out of					
	· ·	I resident to leave					
	alarms alone e	t call for help before					
	getting up."						
	A "Falls Care !	Plan," initially dated					
		cated a problem of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/14/2	ETED	
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE	•	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	2	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
	"History of fa	llsContributing					
	factors, Deme	entia, ArthritisUse of					
	w/cRefusal of assistance, Refusal						
	to use assistiv						
	approaches in	approaches indicated, "Encourage					
	to stay seated	or wait for assistance					
	before transfe	rring after meals.					
	Ensure freque						
	within reach:						
	cord; Water, I						
	use the following preventive						
	measure: Bed						
		TABS Alarm to w/c					
	for n. [nursing	g] measure."					
	On 4/14/11 at	9:00 A.M., the					
		urse provided an					
		ident Report," dated					
		report included,					
	"Noted res						
	**	ry, refer to nurses					
		nal comments and/or					
		nt recurrence: tabs					
	alarm to w/c.'	•					
	4. On 4/13/11	at 9:10 A.M., during					
	the initial tour	t, the compliance					
	nurse indicate	ed Resident C had a					
	diagnosis of A	Alzheimer's Disease,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155621		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE TOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	had a history of alarms.	f falls, and utilized					
	C was observed wheelchair in a self release sea observed on the were observed resident.  The clinical rewas reviewed A.M. Diagnost not limited to, and Parkinson's A Minimum Dassessment, da Resident C had long-term men moderately im skills for daily required extentwo+ staff for mobility, and of	a lounge, asleep. A atbelt alarm was a resident. No staff interacting with the cord of Resident C on 4/13/11 at 11:45 as included, but were Alzheimer's Disease is Disease. The state of the state of transfer and bed did not ambulate. A					
	and walking" i	ce during transitions ndicated "Not steady, abilize with human					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE COMPL	
		155621	A. BUI B. WIN			04/14/2	011
NAME OF F	PROVIDER OR SUPPLIER		_!	1	ADDRESS, CITY, STATE, ZIP CODE	!	
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	VILLE, INTTIZO		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	assistance" wh	ile moving from					
	seated to stand	ling position, moving					
	on and off toilet, and						
	surface-to-surf	face transfer. The					
	MDS assessme	ent indicated the					
	resident had no	ot fallen since the					
	previous asses	sment.					
	Nurses Notes included the						
	following notations:						
	2/15/11 at 5:30	) P.M.: "CNA					
	approached Re	esident room et heard					
	alarm sounding	g. Resident found in					
	bathroom floor	r on [left]					
	sideWhen re	sident asked what					
	happened she	stated 'was going to					
	bathroom.' Res	sident toileted after					
	writer evaluate	ed."					
	2/15/11 at 5:45	5 P.M.: "[Physician]					
	update on inci-	dent. Received new					
	orders for UA,	, C/S [urinalysis,					
	culture and ser	nsitivity]. Also					
	received order	s for self releasing					
	seat belt"						
	A "Falls Care I	Plan," initially dated					
	6/10, indicated	l a problem of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		A. BUI	LDING	00	ľ	E SURVEY PLETED /2011	
		100021	B. WIN		DDDDDD OWN COATE ON COAT		2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER	EVANSVILLE, IN47720				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUI		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
		llsContributing					
	factors, Alzhe	imer's Diagnosis,					
	Forgets to ask for						
	assistanceGe	eneralized					
	weakness" T	he approaches					
	indicated, "E	Encourage to stay					
	seated or wait	for assistance before					
	transferring af	ter mealsIs at risk					
	for falls; will u						
	preventive measure: Sensor pad to						
	bed/recliner12/7/10 tabs alarm to						
	w/c, 2/15/11 S	elf releasing seat belt					
	while in w/c."						
		clinical record of					
	Resident B wa						
		O P.M. Resident B					
		to the facility on					
		liagnoses including,					
	but not limited	<i>'</i>					
	following surg	gery/digestive system.					
	An admississ	ooro plan undatad					
		care plan, undated,					
	indicated: "Fall	•					
	Risk/Elopeme						
		remain free of injuries					
	_	o call bell in reach.					
		Il light. Instruct					
	resident on sat	tety					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K11

Facility ID: 000442

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		A. BUILDING	CONSTRUCTION  00	COM	TE SURVEY  IPLETED  1/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400	ET ADDRESS, CITY, STATE, Z O STOCKER DR NSVILLE, IN47720	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
		bility alarm SPA arm] bed [and]				
	Nurses Notes : following note					
	delusional @ t	A.M.: "Res remains this time D/T [due to] family is here et this nks that nephew was to her"				
	[with] some co	00 A.M.: "Alert onfusionneeds st [with] ADL's aily living]"				
	[sensor pad ala CNA went to resident found floor in front of bruise noted to	P.M.: "Res spa arm] heard sounding, resident's room, lying on back on of closet. Denies pain, plateral left sted to w/c [with]				
		5 P.M.: "Prevantive t recurrent fall -				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		LDING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	ETED	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	3400 ST	DDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	self-release se On 4/13/11 at interview with nurse, she indihave considered interviewable. Resident B has unassisted am 3/25/11, "prob P.M.," and a splaced on the wheelchair. This indicated she documentation attempt at unawas not in the compliance nurse not present whought the alarm, and four self-release sections.	at belt"  2:15 P.M., during a the compliance icated she would not ed Resident B  She indicated	I		TE	
	that she compensure staff ca	had a "falls checklist" letes after a fall, to illed the family and updated the care plan at sheets.				
	This federal ta	g relates to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR WILLE, IN47720	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Complaint IN(3.1-35(a) 3.1-35(d)(2)(E					
F0282 SS=D	facility must be pro in accordance with plan of care. Based on obse	ided or arranged by the ovided by qualified persons in each resident's written ervation, record terview, the facility	F0282	Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Cent		05/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED	
AND PLAN	OF CORRECTION	155621	A. BUI	LDING	00	04/14/2011
		133021	B. WIN			04/14/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	TOCKER DR VILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG				IAG	assure tihati tihe residentis' care	DAIL
		e a bed alarm ordered			plans are fiollowed appropriatiely	v in
	for fall prevention was turned on				accordance witih tihe assessed	,
	[Resident A], f	for 1 of 3 residents			needs.	
	reviewed for falls, in a sample of 6.				The correcton acton taken fior	
	, 1				those residents fiound to be afied	ted
	Findings inclu	da			by the deficient practce include :	
	Findings include:				Residentt#A is now receiving servi in accordance witth tthe plan of c	
					Other residents that have the	laic
	1. On 4/14/11 at 9:30 A.M., the				potental to be afiected have been	1
	facility compli	ance nurse provided			identfied by :	
	the current facility policy on "Falls				All residentts have been reviewed	tto
	Prevention," dated 9/08. The policy				assure tthatt tthey are receiving	
	included: "To	1 2			services in accordance witth tthe off care. The CNA assignmentt she	· I
					appropriattely address residentts	eus
	residents are sa	ate and that			needs based on tthe assessmentt	and
	appropriate pro	eventive measures are			a monittoring systtem has been	
	initiated to min	nimize injuries			implementted tto assure tthatt	
	related to falls	Fall Preventive			intterventtons are appropriattely	in
	MeasuresMo	otion Alarms			place.	
		Motion Sensors,			The measures or systematc changes that have been put into	
	` ′	· · · · · · · · · · · · · · · · · · ·			place to ensure that the deficient	
	Smart Floor M	lat Alarm"			practce does not recur include :	
					The intterdisciplinary tteam will be	e
	2. On 4/13/11	at 9:10 A.M., during			reviewing every flall tto assure tth	
	the initial tour.	, Unit Manager # 1			appropriatte intterventtons are in	
		dent A had fallen the			place based on tthe possible cause tthe flall The plan of care and tthe	
					CNA assignmentt sheetts will be	
	previous night				updatted as needed The nursing	
		Unit Manager # 1			sttafl has been inserviced relatted	tto
	indicated Resid	dent A required a			providing services tto our resident	
	sensor pad alaı	rm to her wheelchair			correlatton witth tthe written plan	n ofl
	and bed. Unit				care. There will be routtne monittoring via rounds tto assure	thatt
		s alarm was added to			alarms are in place and fluncttona	
	maicaica a tao	5 didilii was added to				

000442

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155621	B. WIN			04/14/2011	
					ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF I	PROVIDER OR SUPPLIER			3400 S	TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER			VILLE, IN47720		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	accordance witth tthe residentts'	DATE	
		following the fall			off care	Pian	
	1 *	ight. At that time,			The correctve acton taken to		
	Resident A wa	s observed lying in			monitor perfiormance to assure		
	bed. A request	was made to			compliance through quality		
	determine if th	ne resident's bed			assurance is:		
	sensor alarm was functioning. Unit Manager # 1 checked the alarm,				A Perflormance Improvementt Too has been inittatted tthatt will be	OI	
					uttlized tto randomly review5		
					residentts' comprehensive		
		the alarm was not			assessmentt in correlatton witth t	the	
	turned on. Uni	t Manager # 1 turned			plan ofl care tto assure tthatt tthe	l	
	the alarm on, and instructed the				perttnentt inflormatton based on	tthe	
	resident to "Pr	omise you won't get			assessmentt is accurattely communicatted and being flollow	ed le	
	up without ask	ting for help." Unit			in accordance witth tthe residentt	l	
	l <sup>-</sup>	ndicated she did not			identtfled needs. Alarm placemen	tt	
	l ~				and flunctton will be specifically		
		alarm was not turned			identtfled on tthe monittoring flor		
	on.				The Directtor of Nursingor design will complette tthis ttool weekl&x	l	
					montthly 3, tthen quartterly 3. An		
	The clinical re	cord of Resident A			areas identtfled via tthe auditt wil		
	was reviewed	on 4/13/11 at 10:40			immediattely correctted The Quali	itty	
	A.M.				Assurance Committee will review	tthe	
					ttool att tthe scheduled meettng	a ttool	
	Dhygigian's and	dora initial data			flollowing tthe completton of tthe witth recommendattons as neede	l	
	1 1	ders, initial date			The date the systemic changes w		
		on the current April			be completed:		
	2011 orders, in	ndicated, "Sensor pad			5-14-11		
	alarm to w/c [	wheelchair] d/t [due					
	to] decreased s	safety awareness" and					
	-	·					
	"Sensor pad alarm to bed d/t decreased safety awareness."						
	decreased sale	ry awareness.					
		•					
	This federal ta	g relates to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR VILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 00088724.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	environment remandazards as is possoreceives adequated devices to prevente Based on obserview, and infailed to ensurfor fall prevente [Resident A]; alarms were not supervision; and to alarms time with a fracture for 3 of 3 residente falls, in a samp B, and C  Findings inclusion.	rvation, record terview, the facility e a bed alarm ordered tion was turned on failed to ensure of used in place of and failed to respond ly, resulting in a fall and hip [Resident B], lents reviewed for tole of 6. Residents A,	F0323	F323 Iti is tihe practice ofi Pine Haven Healtih and Rehabilitiation Centie assure tihati tihe The correcton acton taken fior those residents fiound to be affect by the deficient practce include: Residentts#A and #C have been reassessed relatted tto flall risk and have been reviewed by tthe IDT to assure tthatt appropriatte interventtons are in place tto assi with tthe preventton off flallshe plans off care have been updatted well as tthe CNA assignmentt sheel applicable. Residentt#B, as identtfled in tthe2567, no longer resides att tthe flacilitty  Other residents that have the potental to be affected have been identfied by: All residentts have been assessed relatted tto flall riskBased on tthe assessment; intterventtons have b implementted tto assist witth the	een

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155621	B. WIN			04/14/2011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
DIVIE UV	\/EN  HEA  TH AND	REHABILITATION CENTER		1	OCKER DR /ILLE, IN47720	
				<u> </u>	VILLE, IIN <del>t</del> / / 20	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	Prevention." d	ated 9/08. The policy			preventton of flalls The plans of c	are
	included: "To				and tthe CNA assignmentt sheetts	have
	residents are sa				been updatted ifl indicatted	
		eventive measures are			The measures or systematc	
					changes that have been put into	
	initiated to min	J			place to ensure that the deficient	
	related to falls			practce does not recur include :		
	occurs, the Falls Checklist will be initiated with all areas completed before the end of the shift the incident occurredNursing staff will document on the resident chart a thorough accounting of the				The intterdisciplinary tteam is reviewing all flall risk assessmentt.	s tto
					assure tthatt perttnentt areas on t	
					comprehensive assessmentt are	
					identtfled as partt ofl tthe plan ofl	
					Based on the assessmenttthe pla	1
					ofl care is being updatted in additt tto tthe CNA assignmentt sheett if	1
	_	lined in the Falls			indicatted An in-service has been	
					conductted flor tthe nurses tto ass	ure
	Checklist. Fall				tthatt tthere is a tthorough	
	MeasuresMo				understtanding relatted tto tthe is identified on the assessment bei	1
	<b>`</b>	Motion Sensors,			addressed on tthe plan of care flo	- I I
	Smart Floor M	lat			residentt All nursing sttafl has bee	
	AlarmSelf-R	Leleasing Alarm Belts,			in-serviced relatted tto providing	
	RestraintsAl	l preventive measures			services tto residentts in accordan	
		with the resident's			witth tthe plan ofl careAs partt ofl systtem change tthe Intterdisciplin	1
	cognition level				tteam will review all flallsassure tt	· I I
		••			an investtgatton was completteda	nd
	2 On 4/12/11	ot 2:00 D.M. Unit			assure tthatt tthe care plan has be	en
		at 2:00 P.M., Unit			updatted tto reflectt appropriatte interventtons based on the possi	hle
		rovided C.N.A.			cause of tthe fall	
	_	eets for her unit. The				
	assignment sheets indicated that 23 residents resided on that unit. 17 of				The correctve acton taken to	
					monitor perfiormance to assure compliance through quality	
	those 23 reside	ents had some type of			compliance through quality assurance is:	
		alarm, to alert staff			A Perflormance Improvementt Too	ol
	_					
FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete Event ID:	144K11	Facility II	D: 000442 If continuation s	heet Page 35 of 55

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	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:  155621	A. BUI		00	COMPL 04/14/2	
		100021	B. WIN		DDDDGG GITTL GTUTTE GTT GOD-	04/14/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWDENG N. IN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of unassisted r	rising.			has been inittatted tthatt will be		
					uttlized tto randomly review5 residentts tthatt are considered "F	ligh	
	On 4/14/11 at	10:00 A.M., during			Risk ofl Falls" or who have had an		
		the compliance			acttual flall tto assure tthatt prope	r	
	nurse, she indicated that her responsibility was to validate that "everything regarding a fall was documented properly, including updating the care plan." The compliance nurse indicated there was not "really an investigation on				preventive interventions are in pl		
					and tthatt all flalls are tthoroughly investigatted flor proper cause tto		
					assure tthatt appropriatte		
					intterventtons have been		
					implementted in accordance witth		
					assessmentt The ttool will also ass tthatt tthe plan ofl care as well as		
					CNA assignmentt sheetts are upda		
					appropriattely The Directtor ofl		
	_	urs," and that the			Nursing, or designee, will complet		
		tion following a fall			tthis ttool weekly 3, montthly 3, tti quartterly 3. Any areas identtfled		
	would be to ac	ld an alarm.			tthe auditt will be immediattely	-	
					correctted The Qualitty Assurance		
	3. The closed	clinical record of			Committee will review the tool a		
	Resident B wa	as reviewed on			tthe scheduled meettng flollowing completton ofl tthe ttool witth	, une	
	4/13/11 at 1:20	0 P.M. Resident B			recommendattons as needed.		
		to the facility on			The date the systemic changes wi	ii l	
		liagnoses including,			be completed: 5-14-11		
	but not limited	C			J 17 11		
		gery/digestive system.					
		gory/urgestive system.					
	An admission	care plan, undated,					
	indicated: "Fa	•					
		•					
	Risk/Elopeme						
		remain free of injuries					
	_	p call bell in reach.					
	Enc. use of cal	ll light. Instruct					
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	<b>-</b> 44K11	Facility II	D: 000442 If continuation sl	heet Pa	ge 36 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155621	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED 04/14/2011
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)	D BE COMPLETION OPRIATE
resident on safety measuresMobility alarm SPA [sensor pad alarm] bed [and] chair"  Nurses Notes included the following notations:  3/21/11 [untimed]: "Mental status varies over the course of the day. Confused/forgetful. Decreased safety awarenessUp with assist x 1, wheelchair"  3/23/11 "11p-7A": "Confused/Forgetful, Decreased safety awarenessUp with assist"  3/24/11 at 11:00 A.M.: "Confused/Forgetful, Decreased safety awarenessUp with assist [of two]Bathroom with assist"		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/14/2011	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STR 340	00 ST	ADDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	3/25/11 at 11:0 [with] some consists assist x 3"  3/25/11 at 3:30 [sensor pad also CNA went to resident found floor in front of bruise noted to foreheadassist assist x 3"  3/25/11 at 3:43 [sic] to prevent self-release self-relea	200 A.M.: "Alert confusionneeds st [with] ADL's aily living]"  20 P.M.: "Res spa carm] heard sounding, resident's room, lying on back on of closet. Denies pain, or lateral left sted to w/c [with]  25 P.M.: "Prevantive trecurrent fall - at belt"  26 vas transferred to the 25/11 at 4:45 P.M. A					
	was not able to	walk and was left side. It was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED 04/14/2011	
		100021	B. WIN		PDD F00 gym-	04/14/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE FOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		1	VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		catient had a left	-	TAG	DEFICIENC!)		DATE
	femoral neck f						
	Temoral neck i	racture					
	On 4/13/11 at	2:15 P.M., during					
		the compliance					
		cated she would not					
	have considered						
	interviewable.						
	Resident B had attempted						
	unassisted ambulation earlier on						
	3/25/11, "prob	ably around 2:00					
	P.M.," and a so	ensor alarm was					
	placed on the i	resident's bed and					
	wheelchair. Th	ne compliance nurse					
	indicated she of	lid not know why					
	documentation	regarding the					
	attempt at una	ssisted ambulation					
	was not in the	clinical record. The					
	compliance nu	rse indicated she was					
	•	en the resident fell,					
	_	e staff heard the					
		nd her on the floor in					
		compliance nurse					
		nad a "falls checklist"					
	_	etes after a fall, to					
		lled the family and					
		updated the care plan					
	and assignmen						
	compliance nu	rse indicated she did					

Facility ID:

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621		LDING	NSTRUCTION  00	(X3) DATE COMPI 04/14/2	ETED
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	•	3400 ST	DDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	not know if the transferred here						
	the initial tour indicated Resi previous night interviewable indicated Resi sensor pad ala and bed. Unit indicated a tab the wheelchair the previous n Resident A was bed. A request determine if the sensor alarm was Manager # 1 cand indicated turned on. Unit he alarm on, a resident to "Prup without ask Manager # 1 i know why the on.	Unit Manager # 1 dent A required a rm to her wheelchair Manager # 1 os alarm was added to r following the fall ight. At that time, as observed lying in					

000442

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED 04/14/2011	
	PROVIDER OR SUPPLIER		B. WIN	3400 ST	DDRESS, CITY, STATE, ZIP CODE	04/14/2	
PINE HAVEN HEALTH AND REHABILITATION CENTER				<u> </u>	VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	was reviewed	on 4/13/11 at 10:40					
	A.M. Diagnos	ses included, but were					
	not limited to,	Dementia.					
	assessment, da indicated the re of 15 on a cog- required limite staff for transfe and had not fal previous asses "Balance durin walking" indic- only able to sta- assistance" wh seated to stand	esident scored a 9 out nitive assessment, ed assistance of 1 er and ambulation, llen since the sment. A test for ng transitions and eated "Not steady, abilize with human nile moving from					
	1/19/11, indicating intermittent color in the previous balance problem required the usual device, and har The assessment	assessment, dated ated Resident A had onfusion, had 1-2 falls a 3 months, had a cm while standing, se of an assistive d a total score of 12. In tindicated, "Total above represents					

Facility ID:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIF  A. BUILDING  B. WING		NSTRUCTION  00	(X3) DATE: COMPL 04/14/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	ST1	00 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  for falls.	ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	unknown and 2011 orders, in alarm to w/c [to] decreased signs "Sensor pad aldecreased safe"  Nurse's Notes following nota 4/12/11 at 10:0 reports res [restinurse.' Upon a noted resident floor. W/C breassessed for in apparentRes [with] extensive [and] gait belt alarms on et [alight within readded to res. where we will not the same and the same as a decreased safe alarms and the same as a decreased safe."	ations:  20 P.M.: "Staff sident] yelling out entering res bathroom sitting on bottom of eaks [sic] locked. Resigury, none assisted off floor we assist x [two] staffRes. placed to bed, and] functioning, call each. TABS alarm w/c for preventative					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  04/14/2011	
	PROVIDER OR SUPPLIER		STR 340	00 ST	DDRESS, CITY, STATE, ZIP CODE OCKER DR /ILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	[up] getting in off bed alarm bed. Instructed alarms alone e getting up."  A "Falls Care 10/31/10, indic "History of fal factors, DemenwicRefusal of to use assistive approaches independent to stay seated before transfer Ensure frequenwithin reach: Occord; Water, Is use the follow measure: Bed bed4/12/11 for n. [nursing On 4/14/11 at compliance nursing Incident/Accident/Accident/Accident/Incident/Accident/Incident/Accident/Inc	chair. Resident shut [before] getting out of I resident to leave It call for help before  Plan," initially dated cated a problem of IsContributing ntia, ArthritisUse of of assistance, Refusal e devices." The dicated, "Encourage or wait for assistance rring after meals. ntly used items are Call system; Light s at risk for falls; will ing preventive bolsters to TABS Alarm to w/c ] measure."  9:00 A.M., the arse provided an dent Report," dated eport included,					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMP 04/14/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	steps to prever alarm to w/c." regarding a ser or functioning compliance nutime that she was prescribed sen not.  5. On 4/13/11 the initial tour nurse indicated diagnosis of A had a history of utilized alarms.  On 4/13/11 at C was observed wheelchair in a self release sea observed on the were observed resident.  The clinical rewas reviewed A.M. Diagnosis	11:30 A.M., Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155621	A. BUI B. WIN	LDING IG		04/14/2	011
NAME OF F	PROVIDER OR SUPPLIER		·	1	ADDRESS, CITY, STATE, ZIP CODE	!	
PINE HAVEN HEALTH AND REHABILITATION CENTER				1	TOCKER DR VILLE, IN47720		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	and Parkinson	's Disease.					
		Pata Set [MDS]					
		ated 2/8/11, indicated d a short-term and					
		nory problem, was					
	_	paired in cognitive					
	_	decision-making,					
	required extensive assistance of						
	two+ staff for transfer and bed						
	mobility, and did not ambulate. A						
	test for "Balan	ce during transitions					
	and walking" i	indicated "Not steady,					
	only able to sta	abilize with human					
		nile moving from					
		ling position, moving					
	on and off toil	<i>'</i>					
		face transfer. The					
		ent indicated the					
		ot fallen since the					
	previous asses	Silient.					
	Nurses Notes i	included the					
	following nota	tions:					
	2/15/11 + 5.24	DA HONA					
	2/15/11 at 5:30						
	* *	esident room et heard					
	bathroom floor	g. Resident found in					
		[1011]					

		X1) PROVIDER/SUPPLIER/CLIA	(X2)	(2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155621	А. В	BUILDING	00		04/14/2011	
		100021	B. V	WING			04/14/20	711
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STA	TE, ZIP CODE		
PINF HA	VEN HEALTH AND	REHABILITATION CENTER		I	/ILLE, IN47720			
(X4) ID		TATEMENT OF DEFICIENCIES		ID			-	(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV	LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	LSC IDENTIFYING INFORMATION)	)	TAG		ED TO THE APPROPRIATI ICIENCY)	E	DATE
	sideWhen re	sident asked what						
	happened she	stated 'was going to						
		sident toileted after						
	writer evaluate							
	William C variance							
	   2/15/11 at 5·4 <del>4</del>	5 P.M.: "[Physician]						
		dent. Received new						
	•	, C/S [urinalysis,						
		nsitivity]. Also						
	received orders for self releasing							
	seat belt"							
	A "Falls Care	Plan," initially dated						
	6/10, indicated	d a problem of						
	"History of fal	llsContributing						
	factors, Alzhei	imer's Diagnosis,						
	Forgets to ask	for						
	assistanceGe							
		The approaches						
		Encourage to stay						
	ŕ	for assistance before						
	_	ter mealsIs at risk						
		use the following						
	*	asure: Sensor pad to						
		12/7/10 tabs alarm to						
		elf releasing seat belt						
	while in w/c."							
	On 4/14/11 at	10:00 A.M., during						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	  44K1	1 Facility I	D: 000442	If continuation sh	eet Pac	ne 46 of 55

B. WING	1/14/2011					
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720	3400 STOCKER DR					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE					
interview with the compliance nurse, she indicated, "When [Resident C] was down the hall, we would hear the alarms, and by the time we would get there, she would be on the floor. So we moved her closer to the nursing station." The compliance nurse indicated the resident had experienced several falls. The compliance nurse indicated there was not a process in place to determine the cause of the falls.  This federal tag relates to Complaint IN00088724.  3.1-45(a)(2)						

<b>I</b>		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/14/2011
	ROVIDER OR SUPPLIER		3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR	
PINE HA		REHABILITATION CENTER	EVANS	VILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	each resident in according professional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services provipreadmission scresstate; and progress Based on recordinterview, the ensure docume complete regardinvestigation as was functioning documentation regards to a resumassisted ambaddition of sensessional services.	rd review and facility failed to entation was rding a fall and whether an alarm ag [Resident A]; and a was complete in sident's attempt at bulation and the asor alarms [Resident residents reviewed for	F0514	Iti is tihe practice ofi tihis fiacilitiy assure tihati tihe residentis' clinic records are completied appropriatiely in accordance with tihe regulatiory guidelines The correcton acton taken fior those residents fiound to be affect by the deficient practce include: Residentt#A has been reviewed tto assure all appropriatte intterventto are in place relatted tto flall preventton. Ifl tthe residentt were experience an addittonal incident; investtgatton will be conductted to attempt to dettermine the cause the flall so tthat appropriatte	al  ted  on  ons  etto ean o

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **|44K11** 

000442

Facility ID:

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621			A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMP 04/14/2	LETED
		100021	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 0 11 11 11	
NAME OF PROVIDER OR SUPPLIER				1	TOCKER DR		
PINE HAVEN HEALTH AND REHABILITATION CENTER				1	VILLE, IN47720		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	intterventtons can be updatted		DATE
	Findings inclu	ıde.			Residentt#B no longer resides in	tthe	
	i manigs mere	ide.			flacilitty		
	1 0 4/14/11	at 0.20 A M tha			Other residents that have the potental to be afiected have been		
		at 9:30 A.M., the			identfied by :		
	1 1	iance nurse provided			All residentts have been reviewe	d tto	
		cility policy on "Falls			assure tthatt clinical documentta	tton is	
		lated 9/08. The policy			appropriatte  The measures or systematc		
	included: "T	o ensure that			changes that have been put into	)	
	residents are safe and that appropriate preventive measures are initiated to minimize injuries related to falls Nursing staff will document on the resident chart a				place to ensure that the deficien	nt	
					practce does not recur include :		
					The intterdisciplinary tteam is	He He	
					reviewing all flall risk assessmen assure tthatt perttnentt areas on		
					comprehensive assessmentt are		
	thorough accounting of the incident as outlined in the Falls Checklist. Fall Preventive MeasuresAll				identtfled as partt ofl tthe plan o	fl care	
					As partt of tthe review		
					documenttatton relatted tto an incidentt will also be reviewed tt	0	
					assure tthatt itt is inclusive ofl pe		
	l *	easures must be added			inflormatton An in-service has b	een	
	to the Falls Ca	are Plan and			conductted flor tthe nurses tto a	ssure	
	datedPreventive measures must be charted in the nurses notes"				tthatt tthere is a tthorough understtanding relatted tto tthe		
					appropriatte clinical documentta	tton	
					necessary including whetther ala		
	2. On 4/13/11	at 9:10 A.M., during			were sounding appropriattely ifl		
	the initial tour, Unit Manager # 1 indicated Resident A had fallen the previous night, and was not interviewable. Unit Manager # 1 indicated Resident A required a sensor pad alarm to her wheelchair				residentt flalls and tthe importta identtflying ifl residentts are	nce off	
					attempttng tto rise unassistted d	uring	
					tthe course ofl tthe day		
					The correctve acton taken to		
					monitor perfiormance to assure		
					compliance through quality		
					assurance is:	aal	
	and bed. Unit Manager # 1				A Perflormance Improvementt To	וטכו	

000442

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155621 04/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3400 STOCKER DR PINE HAVEN HEALTH AND REHABILITATION CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE has been inittatted tthatt will be indicated a tabs alarm was added to uttlized tto randomly review5 the wheelchair following the fall residentts medical records tto assure the previous night. tthatt tthe clinical record accurattely identtfles perttnentt inflormatton relatted tto tthe residentts and The clinical record of Resident A incidences ofl flallsThe Directtor ofl was reviewed on 4/13/11 at 10:40 Nursing, or designee, will complette A.M. Diagnoses included, but were tthis ttool weekly 3, montthly 3, tthen quartterly &. Any areas identtfled via not limited to, Dementia. tthe auditt will be immediattely correctted The Qualitty Assurance Committee will review the ttool att Physician's orders, initial date tthe scheduled meeting flollowing tihe unknown and on the current April completton of tthe ttool witth 2011 orders, indicated, "Sensor pad recommendattons as needed. The date the systemic changes will alarm to w/c [wheelchair] d/t [due be completed: to] decreased safety awareness" and 5-14-11 "Sensor pad alarm to bed d/t decreased safety awareness." Nurse's Notes included the following notations: 4/12/11 at 10:00 P.M.: "Staff reports res [resident] yelling out 'nurse.' Upon entering res bathroom noted resident sitting on bottom of floor. W/C breaks [sic] locked. Res assessed for injury, none apparent...Res assisted off floor [with] extensive assist x [two] staff [and] gait belt...Res. placed to bed,

PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION (EACH CORRECTION AS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	(X5) PLETION ATE
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720  ID  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PLETION
PINE HAVEN HEALTH AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	PLETION
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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	
IAG   REGULATORI OR LSC IDENTIFTING INFORMATION)   IAG   Section (1)	AIE
alarms on et [and] functioning, call	
light within reach. TABS alarm	
added to res. w/c for preventative	
nursing measure related to	
decreased safety awareness."	
A "Falls Care Plan," initially dated	
10/31/10, indicated a problem of	
"History of fallsContributing	
factors, Dementia, ArthritisUse of	
w/cRefusal of assistance, Refusal	
to use assistive devices." The	
approaches indicated, "Encourage	
to stay seated or wait for assistance	
before transferring after meals.	
Ensure frequently used items are	
within reach: Call system; Light	
cord; Water, Is at risk for falls; will	
use the following preventive	
measure: Bed bolsters to bed4/12/11 TABS Alarm to w/c	
for n. [nursing] measure."	
Documentation regarding the use of	
sensor pads to the bed and	
wheelchair was lacking.	
On 4/14/11 at 9:00 A.M., the	
compliance nurse provided an	
"Incident/Accident Report," dated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CON	00		COMPL	ETED
	155621		B. WIN	IG			04/14/2	011
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STA	TE, ZIP CODE		
		REHABILITATION CENTER		3400 STOCKER DR EVANSVILLE, IN47720				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV	PLAN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEF	ICIENCY)		DATE
		eport included,						
	"Noted res o	on floor[no]						
	apparent injury	y, refer to nurses						
	noteAddition	nal comments and/or						
	steps to prever	nt recurrence: tabs						
	alarm to w/c."	Documentation						
	regarding a ser	nsor alarm sounding						
	or functioning	was lacking. The						
	_	irse indicated at that						
	time that she was unaware if the							
	prescribed sensor alarm sounded or							
	not, and indicated that fact should							
	be in the nurses notes.							
	3. The closed clinical record of							
	Resident B was reviewed on							
	4/13/11 at 1:20 P.M. Resident B							
	was admitted to the facility on							
		liagnoses including,						
	but not limited to, Aftercare							
	following surgery/digestive system.							
	An admission	care plan, undated,						
	indicated: "Fal							
		•						
	Risk/Elopement Risk. Goal:							
	Resident will remain free of injuries							
	and falls. Keep call bell in reach.							
	Enc. use of call light. Instruct							
	resident on saf	tety						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	I44K11	Facility II	D: 000442	If continuation sh	ieet Pa	ge 52 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COM	(X3) DATE SURVEY  COMPLETED  04/14/2011			
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE		
		bility alarm SPA arm] bed [and]						
	Nurses Notes : following note							
	delusional @ tres thinks her	A.M.: "Res remains this time D/T [due to] family is here et this nks that nephew was to her"						
	3/25/11 at 11:00 A.M.: "Alert [with] some confusionneeds extensive assist [with] ADL's [activities of daily living]"							
	[sensor pad ala CNA went to resident found floor in front of bruise noted to	P.M.: "Res spa arm] heard sounding, resident's room, lying on back on of closet. Denies pain, b lateral left sted to w/c [with]						
		2:15 P.M., during the compliance						

	2011					
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720	3400 STOCKER DR					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY	(X5) COMPLETION DATE					
nurse, she indicated she would not have considered Resident B interviewable. She indicated Resident B had attempted unassisted ambulation earlier on 3/25/11, "probably around 2:00 P.M.," and a sensor alarm was placed on the resident's bed and wheelchair. The compliance nurse indicated she did not know why documentation regarding the attempt at unassisted ambulation was not in the clinical record.  This federal tag relates to Complaint IN00088724.  3.1-50(a)(1)						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	A. BUILDING B. WING	00	COMP 04/14/	LETED		
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		